EXHIBIT 7

ECU Health Non-Compliance Issues

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Association of Health Care Journalists

IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE

VIDANT MEDICAL CENTER

2100 STANTONSBURG RD GREENVILLE, NC 27834 | Voluntary non-profit - Private

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Report date	Number of violations	
Sept. 17, 2020	6 (click for details)	Read full report
Jan. 16, 2020	1 (click for details)	Read full report
April 17, 2019	1 (click for details)	Read full report
Feb. 14, 2019	1 (click for details)	Read full report
Aug. 31, 2017	2 (click for details)	Read full report
May 5, 2016	2 (click for details)	Read full report
July 16, 2015	9 (click for details)	Read full report
Oct. 1, 2014	6 (click for details)	Read full report

Specific Violations

- **Violation:** GOVERNING BODY
- **Violation:** PATIENT RIGHTS
- **Violation:** PATIENT RIGHTS: CARE IN SAFE SETTING
- **Violation:** PATIENT RIGHTS: RESTRAINT OR SECLUSION
- **Violation:** NURSING SERVICES
- **Violation:** RN SUPERVISION OF NURSING CARE

Feb. 16, 2011	3 (click for details)	Read full report

AHCJ

Association of Health Care Journalists

IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE

or google HospitalInspections.org

This is a public website

Home -> North Carolina -> VIDANT MEDICAL CENTER

VIDANT MEDICAL CENTER

Formerly Pitt Memorial Hospital

2100 STANTONSBURG RD GREENVILLE, NC 27834 | Voluntary non-profit - Private

Currently ECU Health

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Violation: QAPI
Violation: PROGRAM SCOPE, PROGRAM DATA

Oct. 1, 2014	6 (click for details)	Read full report

Department of Health & Human Services
Centers for Medicare & Medicaid
Services 61 Forsyth Street, SW, Suite
4T20 Atlanta, Georgia 30303-8909

Ref: Vidant Medical Center— 34-0040

Important Notice — Please Read Carefully

October 9, 2014

Mr. Brian Floyd, President
Vidant Medical Center
2100 Stantonsburg Rd
Greenville, NC 27834-2818

RE: CCN: 34-0040

Dear Mr. Floyd:

Institutions accredited as hospitals by the Joint Commission (JC) are deemed to meet all of the Medicare Conditions of Participation for hospitals. Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct surveys of accredited hospitals participating in the Medicare program if there are "substantial allegations" indicating serious deficiencies that could potentially affect the health and safety of patients.

A substantial allegation survey was conducted at Vidant Medical Center by the North Carolina State Survey Agency from September 30, 2014 through October 1, 2014, with immediate jeopardy being identified on October 1, 2014 as a result of events occurring on May 9 and May 10, 2014. A copy of the deficiencies cited during this survey is enclosed. Specifically, the facility does not meet the following conditions of participation:

42 CFR 482.12 Governing Body
42 CFR 482.13 Patient Rights 42
CFR 482.23 Nursing Services

When a hospital, regardless of its JC accreditation status, is found to be out of compliance with one or more Conditions of Participation, and immediate or serious threat to patient health and safety exists, a deter _ruination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case or Vidant Medical Center and accordingly, the Medicare provider agreement between Vidant Medical Center and the Secretary of the Department of Health and Human Services is being terminated. This termination will be effective November 1, 2014.

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after November 1, 2014. For patients admitted prior to November 1, 2014, payment may continue to be made for a maximum of 30 days for inpatient

hospital services furnished on or after **November 1, 2014.** You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on **November 1, 2014,** to your fiscal intermediary to facilitate payment for these individuals.

We will publish a public notice in a local newspaper prior to the termination date. Termination can only be averted by correction of these deficiencies by **November 1, 2014.** Should we not hear from you, we will assume that the situation has not been corrected. **If you believe that compliance has been achieved, you should notify CMS and the North Carolina State Survey Agency in writing on or before October 15, 2014 describing in detail the specific corrective measures taken to resolve these problems and include acceptable completion dates.** *An acceptable plan of correction must contain the following elements:*

1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;
2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
4) The title of the person responsible for implementing the acceptable plan of correction.
5) The signature of the person responsible for implementing the acceptable plan of correction.

If your "credible allegation" of compliance is accepted, the North Carolina State Survey Agency will be authorized to conduct a resurvey to determine if the conditions which constituted immediate jeopardy have been removed and may conduct a full survey of all conditions of participation. Please be advised, however, that failure to remove conditions that constituted immediate jeopardy will result in your hospital's termination under Medicare, effective **November 1, 2014.** If the Centers for Medicare & Medicaid Services determine that the reasons for termination remain, the effective date of the termination remains **November 1, 2014,** and you will be so informed in writing. If corrections have been made, the termination procedures will be halted, and you will be notified in writing.

If you believe that this termination decision is incorrect, you may request a hearing before an Administrative Law Judge (ALJ) at the Departmental Appeals Board, Department of Health and Human Services. Procedures governing this process are set out in section 42 CFR 498.40, et seq. To be effective, a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to the following address:

Sandra M. Pace
Associate Regional Administrator
ATTN: Rosemary L, Robinson
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

We will forward your request to the Departmental Appeals Board. The request for a hearing should state why CMS's decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by legal counsel.

If there are any questions, please contact Rosemary L. Robinson at (404) 562-7405 or rosemary.robinsoia(icms.fills.izov.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

Enclosure
CMS 2567

cc: JC
State Agency

Printed: 10/30/2014 1:29:33PM
Due Date: 09/24/2014
Priority: IJ

Intake ID: NC00100627
Facility ID: 933410 / HOSP-ACU
Provider Number: 340040
State Region: NCE

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: VIDANT MEDICAL CENTER
Address: 2100 STANTONSBURG RD
City/State/Zip/County: GREENVILLE, NC, 27834, PITT
Telephone: (252) 847-4100

License #: H0104
Type: HOSP-A
Medicaid #:
Administrator:

INTAKE INFORMATION

Taken by - Staff: [redacted]
Location Received: COMPLAINT INTAKE UNIT
Intake Type: Complaint
Intake Subtype: Federal COPs, CFCs, RFPs, EMTALA, CLIA
External Control #:
SA Contact: [redacted]
RO Contact:
Responsible Team:
Source: Family

Received Start: 09/15/2014 At 09:55
Received End: 09/22/2014 At 09:55
Received by: Telephone
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Phone	EMail
CYNTHIA AVENS (Primary) Link ID: 143WF1 Relationship : mother Confidentiality Requested : Y	400 POPLAR STREET WELDON, NC 27890	H: (252) 678-8300	

RESIDENTS/PATIENTS/CLIENTS

Name	Admitted	Location	Room	Discharged	Link ID
KEISHA WHITE	04/16/2014	deceased	unknow	05/10/2014	1088853

INTAKE DETAIL

Date of Alleged: Time: Shift:

Standard Notes: See attached 'Tweets' on internet. Resident in room 311 on south tower Nephrology.

Patient had diagnosis of Lupus, Acute Renal Failure and required oxygen. Patient transferred to hospital on 04/17/14 from Halifax Regional.

Laboratory results dated 05/09/14 showed patient potassium high and ammonia level in patient blood was high.

At midnight of 05/10/14 patient had slid out of bed onto the floor in room. Hospital staff restrained patient to bed. Caller spoke to doctor and stated patient had not exhibited behaviors before. Doctor informed caller was planning to dialyze patient.

Caller alleged the restraints hospital placed on patient was violation of patients rights under the federal level. Restraints were not because patient was combative to staff and restraints used only at least measure. Hospital did not provide sitter in room or a bed alarm.

On 05/10/14 at 3:45 am, staff medicated patient for pain with Ativan. Caller left hospital to get patient a cell phone from Wal-mart at same time since patient would be resting. Nurse told pt's son pt was resting peacefully patient had disconnected monitor. Nurse had failed to reconnect monitor to patient after patient had pulled off monitor.

On 05/10/14 at 5: 45 am Caller returned to hospital with cell phone and upon entering floor, heard a Code Blue in Room 311 , patients room.

Caller was informed patient heart beat was 10-15 beat a minute and patient put on life support. Doctor stated patients had abnormal heart and pulse, had apnea, pulled out Foley catheter and monitor in patients room stopped reading.

Patient died 05/10/14 and caller stated was told was an unexpected death and autopsy would be ordered.

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No autopsy done. Death certificate stated: Anoxic Brain Injury, CPR arrest, Lupus and Acute Renal Failure.

Caller stated Police Department of Greenville notified, Hospital Police notified, Patient Care Coordination, Risk Management, SBI and Attorney General notified.

9/22/14 Investigate nursing services. (dm)

9/26/14: Complainant called with add'l information. Complainant corrected admit date from 4/17/14 to 4/16/14. On 5/09/14 pt was on Nephrology Unit, 3rd South Tower, room 31. Pt had stage II renal failure Complainant obtained med record from facility.

Complainant stated prior to evening of 5/09/14 pt was asking for PRN pain med every two hours. Pt had sores on buttocks and vaginal area which caused pain. Complainant stated on 5/09/14 nursing staff did not assess vital signs and pain levels from 7:00 PM on 5/09/14 till 6:00 AM on 5/10/14. Nurse assigned to pt was [redacted]. Pt became increasingly agitated (not pt's usual behavior) on 5/09/14-5/10/14. Pt complained of feeling hot and slid out of bed to get cool. Pt pulled catheter out. Pt pulled off monitor leads. Complainant was with pt at about midnight on 5/10/14 when pt was attempting to slide self out of bed.

After midnight on 5/10/14 nurses placed pt in wrist restraints and soft vest restraint due to agitation. Pt's HOB was elevated at 30 degree angle. Pt could not reach call bell because wrist were restrained. Complainant asked staff about pain management at about 3:00 AM on 5/10/14. Charge nurse told complainant nurse would contact physician to change PRN order to scheduled order. Complainant did not believe pt was cognitively capable to request PRN pain med but was in pain. Pt also had elevated ammonium level.

Complainant stated after 3:00 AM on 5/10/14 staff never reconnected pt to monitor because monitoring stopped at 3:45 AM. Pt was supposed to be monitored remotely and at nurses station. Complainant stated no audible alarms were sounding in pt's room. Complainant did not believe pt was monitored while in restraint. Complainant stated at about 4:00 AM pt was documented as resting quietly. Complainant questioned the need for continued wrist and/or vest restraint.

Complainant reviewed med records and 28-30 oxygen saturation levels from 1:46 AM onward on 5/10/14 were not documented until 5/11/14 at 7:35 PM. Complainant believed the nursing staff were recreating the medical record to cover up lack of monitoring.

Complainant stated physician note indicated pt was found "slumped over" non-responsive. Complainant stated pt could not be slumped because pt was in vest restraint. Code was called at 5:45 AM on 5/10/14. Weak heart rate returned after 15-16 mins of CPR efforts. Pt was taken to MICU with pupils fixed/dialated and no active respiratory effort./dgg

9/26/14: Acute Care Team notified of add'l information via email./dgg

Extended RO Notes:

Extended CO Notes:

ALLEGATIONS

Category: Nursing Services
Subcategory:
Seriousness: Critical
Findings: Substantiated:Federal deficiencies related to alleg are cited
Deficiencies Cited: Fed-A-0043-GOVERNING BODY (482.12)
Fed-A-0115-PATIENT RIGHTS (482.13)
Fed-A-0144-PATIENT RIGHTS: CARE IN SAFE SETTING (482.13(c)(2))
Fed-A-0174-PATIENT RIGHTS: RESTRAINT OR SECLUSION (482.13(e)(9))
Fed-A-0385-NURSING SERVICES (482.23)
Fed-A-0395-RN SUPERVISION OF NURSING CARE (482.23(b)(3))
Details: The hospital nursing staff failed to evaluate and supervise the care of a patient.

Findings Text: An unannounced on site complaint investigation was conducted from September 30 - October 1, 2014. The investigation included review of hospital policy, job descriptions, closed medical record review, monitor technician log review, and staff interviews.

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Review of the hospital's policy, "Physiologic Alarm Settings", effective 07/2011, revealed, "PURPOSE : To provide safe environment through maintenance of monitor alarm settings of patient's physiological data and documentation of data strips....DOCUMENTATION: ECG: A recording of each patient's ECG rhythm strip* will be obtained on admission and at the beginning of each shift and documented on the Rhythm Strip Analysis Sheet."

Review of the hospital's "Cardiac Monitoring Program Guidelines", revised 03/01/2014 revealed "The following are the procedures to follow to communicate patient status for all units that are monitored by the Cardiac Monitoring Program. ..." Review revealed an algorithm for Monitor Techs to follow when monitor leads are off. The algorithm revealed "...If the patient remains off the monitor/ leads remain off/ or battery is not changed after notifying the clinical staff", then the monitor tech is to contact the clinical staff every 15 minutes for two times. If the issue has still not been resolved, the Monitor Tech is to "Contact the Charge Tech". The Charge Tech "will go to the unit and discuss the issue with the Charge Nurse for resolution. Charge Tech will not leave the unit until the issue is resolved."

Review of Hospital Document "(Hospital Initials) ADULT GENERAL CARE UNIT SCOPE OF SERVICE" revealed 3 South (general medical cardiac monitored unit) was "...designated to provide service to the stable young adult to geriatric population requiring continuous cardiac monitoring". Review revealed Vital Sign frequency as every 4 hours or greater.

Review of the hospital's job description for a Staff Nurse I, dated 11/07/2013, revealed, "...Position Summary: Deliver direct, quality patient care, utilizing a basic clinical skill level and knowledge base. Develop, implements and evaluates/revises a plan of care.....Responsibilities. Provides age specific direct patient care according to unit scope of service....Interprets overt assessment data to determine when patient is at acute physiological and or psychosocial risk....Follows hospital policies and procedures and unit protocols....Demonstrates competency in basic nursing practice and mastery in the use of nursing process. ..."

Review of the hospital's Monitor Technician job description, dated 3/21/2012, revealed "...Responsibilities 1. Observes base station monitors and identifies life threatening arrhythmias of changes in patient's rhythm. 2. Notifies responsible RN of changes in patient's cardiac rhythm. ..."

Closed medical record review of the named patient revealed a 26 year old female admitted on 04/16/2014 with a history of systemic lupus erythematosus (SLE - a disease where the body's immune system mistakenly attacks healthy tissue), antiphospholipid syndrome (can cause blood clots to form), rheumatoid arthritis (inflammation and painful swelling of the joints), vasculitis (inflammation of blood vessels), previous left forefoot amputation (removed part of left foot), chronic kidney disease, recurrent perianal abscesses (collection of pus around the anus), anemia (low blood count), and elevated blood pressure. Review revealed the patient was admitted, after transfer from a community hospital, to an intermediate cardiac monitored care unit. Review of physician orders revealed an order on 04/17/2014 for continuous cardiac monitoring and continuous pulse oximeter monitoring "until specified". On 04/20/2014 the patient was transferred to a Monitored General Medical Unit. Record review revealed continuous cardiac monitoring was reordered on 05/03/2014 at 1427 to include "...Transport off monitor per Nursing Assessment Guidelines. Documentation of flow sheets on 05/09/2014 at 0800, documented at 1228, revealed the named patient was on "room air" with a cardiac rhythm of "Sinus Rhythm". Review of Nursing Progress Notes, dated 05/09/2014 at 1900, revealed "Continues to holler out and cry. When asked if she needs anything. She says 'nothing'. Informed patient that her mother is coming to see her. Patient was in bathroom. Denied needing help, but continues to cry out saying she needs help." Flow sheet review revealed on 05/09/2014 at 2000 Vital Signs were obtained with Pulse 88, Respirations 22, Blood Pressure (BP) 125/89, and SpO2 (pulse oximeter oxygen saturation) 100% (normal 95-100%). Further review revealed RN #1 assessed the patient on 05/09/2014 at 2215 (documented 05/10/2014 at 0226) as "Anxious; Restless, Agitated. Further review revealed at 2215 (documented at 0226) the patient was meeting the "cardiac standard", and was in "Sinus Rhythm" and "denied pain". Review of Nursing Progress Notes revealed on 05/09/2014 at 2217 "...Patient had pulled her urinary catheter out. 'No, I do not want it.' states patient. MD to be notified." Further review of Nursing Progress Notes revealed at 2241 "(urinary catheter) balloon intact. Informed patient that we can leave the (urinary catheter) out for now. Cardiac leads off of patient. Patient had pulled those off too. ..." Review of flow sheets revealed on 05/09/2014 at 2310 the patient complained of Pain as 10 (excruciating). Medications revealed on 05/09/2014 at 2310 Dilaudid (narcotic pain medication) 2 mg IV and Ativan (anti-anxiety medication) 0.5 mg IV were administered for pain and agitation. Record review of a Non-violent/ non-self-destructive restraint flow sheet revealed on 05/10/2014 at 0000, the patient was "Pulling at/Removing Lines/Tubes; Pulling at/Removing Dressings/Equipment; Thrashing leg(s)/compromising treatment modalities; Injury to self/Others; Unable to follow safety instructions...Further review revealed on 05/10/2014 at 0000 the patient was "Agitated; Anxiety: Confused; Delusional; Restless" and "...Attempting to get out of Bed/Chair." Review of Nursing Progress Notes revealed on 05/10/2014 at 0011 "Phone call to MD on-call to get order for restraints. Patient crawling OOB (out of bed) between rails. Mother of patient was in the room and could not hold patient in the bed, patient constantly pulling off cardiac leads, pulled out (urinary catheter) earlier. Patient very agitated. Ativan and Dilaudid given earlier. Patient was stating she was hot and wanted to sleep on the floor, this was when patient crawled out of the bed with all siderails up. (RN #3) Charge Nurse notified and in with patient. Restraint put on due to safety issues... ."

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Review of Physician Orders revealed an order from NP #1 on 05/10/2014 at 0027 for arterial blood gases. Further review revealed the order was discontinued at 0052. Review did not reveal evidence that a blood gas was drawn. Review of MD Progress Notes on 05/10/2014 revealed NP #1 visited the patient at 0033 because nursing staff reported agitation and confusion. Further review of his Progress Notes revealed the patient was in bilateral wrist restraints and vest restraint, denying pain. Progress Note review revealed an assessment of "acute agitation" and a plan to keep the patient restrained for patient safety as "she is trying to get up, and does not appear safe to do so unsupervised." Review of Physician Orders revealed an order on 05/10/2014, documented at 0142, to "Restrain for non violent reasons." Restraints ordered were "Upper Soft" and "Vest", with a purpose of "High Risk of Unintended Injury/Trauma to Self" and "Unintentional Interference with Necessary Treatment/Devices". On 05/10/2014, documented at 0151, review of orders revealed an order for Oxygen 2 liters per minute. Record review of Flow Sheets and Nursing Progress Notes did not reveal documentation of oxygen being applied. Further review of Flow Sheets revealed vital signs at 0200, including Pulse 89, BP 131/102, and SpO2 62% (low). Record review did not reveal documentation that RN #1 notified a physician/ provider or the Charge Nurse of the 62% oxygen saturation result. Record review revealed the readings at 0200 were the last validated readings by RN #1 (3 hours, 51 minutes before the cardiac arrest/ code blue was initiated). The last pulse electronically recorded was 88 at 0213. Record review failed to reveal any cardiac monitoring after 0213. Record review did reveal multiple SpO2 readings recorded in the medical record from 0323 to 0354, ranging from 1% at 0336 to 100% at 0341. Record review did not reveal that RN #1 validated these readings, instead they were validated by RN # 2 (who responded to the Code Blue) on 05/10/2014 at 0643 (after the code blue was initiated). Review of Flow sheet revealed Pain Assessment at 0317, with pain intensity of 10 (on scale of 0-10). Review of Medications revealed Dilaudid 2 mg IV administered on 05/10/2014 at 0317. Review of the "Pain Assessments Sedation Scale", revealed at 0354, documented by RN #1 at 0405, "...Eyes closed, easy to arouse (acceptable, no action necessary)." Further review revealed SpO2 of 65% (validated by RN #2 at 0643, not validated by RN #1). Review of Nursing Notes and Flow Sheets failed to reveal restraint release or application of monitor leads at this time. Further review of Nursing Progress Notes did not reveal documentation to indicate the patient was placed back on cardiac monitoring after restraints were initiated nor did it reveal any additional notification to Charge Nurse or Physician related to cardiac monitoring or change in patient condition. Review of the "Code Blue Note", 05/10/2014 at 0551, revealed "...Responded to code blue, on arrival CPR (Cardiopulmonary Resuscitation) in progress... ." Review of Discharge/ Death Summary revealed "on 5/10/2014 the patient had several episodes of confusion and agitation. She received Ativan and Dilaudid. Patient was also given one dose of Bumex for worsening pulmonary edema. She was later found unresponsive and cold. Code blue was called and patient was found to be in PEA (pulseless electrical activity or cardiac) arrest. She received CPR, epinephrine x 3 (3 times) and was intubated with ROSC (Return of Spontaneous Circulation) after 15 minutes. She was transferred to MICU for further management....Pupils were fixed and dilated, no respiratory effort and pH of 6.9. CT head was obtained which showed changes consistent with global hypoxic ischemic injury. ..." The patient expired on 05/10/2014 at 1302. Continued review of the Death Summary revealed "Principle Diagnosis: Anoxic brain injury secondary to PEA (pulseless electrical activity) arrest."

Review of the "Monitor Technician - Daily Patient Activity Log" revealed the named patient was off the monitor (monitor leads off) on 05/09/2014 at 2145. Review revealed RN #1 was notified, with explanation of "will go check on pt (patient) and leads. Review revealed at 2235, monitor leads were off and RN #1 was notified, with explanation "pt refusing monitor orders". Review revealed at 2302 the patient was on the monitor. On 05/10/2014 at 0005, log review revealed the RN was with the patient, the patient had fallen. Further review revealed the CT (Charge Technician) was notified at this time. On 5/10/2014 at 0009, review revealed the patient was on the monitor. At 0044, monitor leads were off. Review revealed at 0044 "CP (Care Partner) not logged in", at 0045 "RN not available", at 0047 "no answer at Sect. (secretary) desk", at 0048 "no answer at CN (Charge Nurse) number", and at 0049 "CT notified". At 0054 review revealed monitor leads were off, the monitor tech spoke with RN #1, and description/explanation documented was "Pt (patient) refusing monitor again, MD is aware of situation and ordered ABG's (Arterial Blood Gases)". Further log review revealed on 05/10/2014 at 0200 leads were off, RN #1 was notified, and explanation documented was "OK, pt refusing, pt in restraints". Continued log review revealed on 05/10/2014 at 0300, 0407, and 0537 monitor leads were off, RN #1 was notified, and the explanation was "pt refusing" each time. Review of the Monitor Log failed to reveal documentation of monitor leads being on or the patient being monitored after 0044. On 05/10/2014 at 0551, log review revealed "Code blue called on pt, pt still off monitor, CT notified."

Review of "Charge Technician Code Blue Report" revealed a description of the events was "Code Blue called @ (at) 0551 prior to code (Monitor Technician #1) was notified by (RN #1) that patient was refusing monitor. Patient started refusing monitor @ 2235 until time of code. Charge Tech check on patient Code Team still working on patient 0605... ."

Interview on 09/30/2014 at 1430 with Administrative Staff #1 revealed the named Patient was confused and agitated on 05/10/2014. Interview further revealed the patient was not on a cardiac continuous monitor per the physician's order. Interview further revealed that on 05/10/2014 at 0200, RN #1 assessed the patient's oxygen saturation as 62% (low) and did not notify the physician of a change in the patient's status. Interview further revealed that RN #1 "did not recognize hypoxia (lack of oxygen). She chose to ignore all the warnings for this

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patient".
Telephone interview on 10/01/2014 at 1500 with Unit Secretary (US) #1 revealed she remembered the patient. Interview revealed, "she was very needy a couple of days prior to her death. She changed. She started falling and getting out of bed. On May 9th, her call bell kept going off. I went down to her room about 11:00 (pm) and she was on the floor. I notified the Charge Nurse (RN #3). She fell at least three times that night". Interview further revealed, "(RN #3) said she had her cardiac leads back on".
Telephone interview on 10/01/2014 at 1655 with Monitor Tech #1 revealed he was monitoring the 3 South cardiac monitors on 05/09/2014 at 1900 until 05/10/2014 at 0700. Interview revealed, "We were very busy that night. (The named patient) was off the monitor at 1900. I called the Unit Secretary. I called the nurse (RN #1) several times that night. I went down to the room during a bathroom break. She (RN #1) was frustrated that night, maybe because of her patient load. She said (the patient) refused the monitor. I called (RN #1) hourly to see if (the patient) was still refusing. I called (Monitor Charge Tech) to let her know (the patient) was refusing to have her leads on, hoping she would call the nurse about the patient not being on the monitor". Interview further revealed, "Our department is closing because according to (Name of Administrative Staff), the nurses don't trust the monitor techs. A lot of nurses don't know their rhythms".
Telephone interview on 10/01/2014 at 1510 with a Monitor Charge Technician (#1) revealed she was the supervising Monitor Charge Technician on 05/09-10/2014. Interview revealed, "the monitor tech said (the patient) was refusing the monitor. The monitor tech called the nurse and she said she wasn't going to put (the patient) back on the monitor". Interview revealed Monitor Technician #1 kept calling the Monitor Charge Technician (#1), because he wanted to her to "make the RN put (the patient) on the monitor". Interview revealed "I can't make them put them on the monitor". Interview revealed, "I couldn't go down to the unit because I was sitting on 3 West monitoring because they had a call out". Interview further revealed, "We didn't have a supervisor to call. We didn't have anybody to call".
Telephone interview on 10/01/2014 at 1230 with RN #3 revealed she was the Charge Nurse for the 3 South Unit on 05/09/2014 beginning at 1900 until 05/10/2014 at 0700. Interview revealed, "when I was making rounds, the Care Partner told me they were not letting (the patient) out of bed because she was falling. She had fell with the nurse in the bathroom and with her Mom. (She) was real restless. She wanted to lay on the floor. I told her Primary Nurse (RN #1) to call the physician. The nurse practitioner came to see her around midnight. (The Patient) was placed in restraints because she was agitated and had pulled her Foley out and took her cardiac leads off". Interview further revealed, "she should have been placed back on the cardiac monitor. The monitor tech never called me. He was able to get up with (RN #1). (RN #1) never told me anything about her sats (oxygen) dropping". Interview further revealed, "I made rounds at the beginning of the shift. I went to her room each time she fell. It was a very busy night. We had 38 patients. We were fully staffed". Interview further revealed, "(RN #1) never reported any of her behaviors - anxious, moving about, wanting to be cooler, getting out of bed, to me. They are all signs of decreased oxygen. (RN #1) did not notify me of a change in her (the Patient's) condition. Both of us should have called the doctor if we knew about it".
Telephone interview on 10/01/2014 at 1530 with Nurse Practitioner #1 revealed he works with the hospitalist service and he remembered the Patient. Interview revealed, "I got a call from a nurse around midnight (05/10/2014) about (the patient) being agitated, impulsive and attempting to get out of bed. I went to see her. She was anxious, trying to get out of bed, wanting to go to the bathroom. She was alert but was fixated on going to the bathroom. A restraint was ordered to keep her in the bed and to keep the monitor (cardiac) on. I initially ordered ABGs (arterial blood gases) but after I went to see her, I didn't see a need. Her chest sounded ok". Interview further revealed, "I expected her to be reconnected to the cardiac monitor. The nurse didn't call me saying it was not reconnected. The nurse didn't call me to let me know her O2 sats (saturation) were dropping. I expected oxygen to be on, too". Further interview revealed, "I expected the nurse to call me if her (the Patient's) condition changed. I did not get a call from the nurse".
Interview on 10/01/2014 at 1005 with Care Partner (CP) #1 revealed the CP was a Nursing Assistant II and was assigned to the named Patient on 05/09/2014 beginning at 2300 until 05/10/2014 at 0700. Interview revealed, "when I arrived to her room, she was on the floor saying she was hot. She wanted to sleep on the floor. She had taken her (cardiac) leads and her gown off. There were 5 or 6 people in the room with her. I got back to her room around 11:30 to take her vitals. I wasn't able to get them because she was flailing her arms, saying she was hot. I put her back to bed and her skin was cool. I told the nurse (RN #1) and she gave her some Ativan. She (the patient) slid out of bed. Her mother was right beside her but her mother couldn't keep her in the bed. She was little and she could slide between the rails. The nurse put her in restraints. She continued to be agitated, even in restraints. She didn't have the pulse ox (oximeter) or the cardiac monitor on after she was restrained. (RN #1) said she wasn't going to put them back on because she had already put 4 sets on her. About 4:30 (am) she calmed down. About 5:45, her mother left the room. She had slid down in the bed so I went to get another Care Partner to help me pull her up. When I got back, her head was turned to the side and I couldn't get her to respond. Her nurse was in the next room. I notified her. A Code was called".
Interview on 10/01/2014 at 0850 with RN #2 revealed the RN was a member of the Emergency Response Team and responded to the Code Blue for the named Patient on 05/10/2014 around 0600. Interview revealed, "CPR (Cardio-Pulmonary Resuscitation) was in progress, chest compressions were being done and the patient was being bagged without an artificial airway. She was not on the cardiac monitor. She had on a Posey vest. I cut it off. I put the pads (defibrillator) on and she was asystole (no cardiac electrical activity). She was getting ACLS (Advanced Cardiac Life Support) meds (medications) and got a rhythm back without shocking (the heart)".

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Interview further revealed, "I read the record after she was transported to MICU (medical intensive care unit). She had been showing signs of hypoxia all night - agitated, restless, picking at self, pulling out her Foley (urinary catheter), taking the leads (cardiac) off". Further interview revealed, "Once she was restrained, she should have been hooked back up to the cardiac monitor. I rounded on the unit prior to the event, sometime after midnight, and nobody mentioned this patient to me". Interview further revealed, "I went to the monitor tech room the next night to look at her rhythm and vital signs before the event and there was a lot of missing data". Interview confirmed that the nursing staff caring for her on 05/10/2014 failed to evaluate and supervise the care of the Patient.

Telephone interview on 10/01/2014 at 1630 with Care Partner #2 revealed she remembered the named Patient. Interview revealed, "she was in a lot of pain. I was her Care Partner on 05/09/2014 from 7 o'clock (pm) until 11 o'clock (pm). She wasn't herself. She was up and down, out of bed, fidgeting, agitated and uncomfortable. She told me she was having trouble breathing. She had oxygen but she wouldn't wear it. I put it back on. I can only give her 2 liters of oxygen. I told the nurse (RN #1) she was having trouble breathing. (RN #1) didn't listen to what I was saying. I told the Charge Nurse (RN #3) that she was having trouble breathing". Interview revealed, "she should have been transferred off that floor the first four hours I was there. Something wasn't right".

Based on the investigative findings the allegation the hospital nursing staff failed to evaluate and supervise the care of a patient was substantiated.

SURVEY INFORMATION

Event ID	Start Date	Exit Date	Team Members	Staff ID
3K0D11	09/30/14	10/01/14	[redacted]	[redacted]

Intakes Investigated: NC00100627(Received: 09/22/2014)

SUMMARY OF CITATIONS:

Event ID	Exit Date	Tag
3K0D11	10/01/2014	
		Federal - Link to This Intake
		A0395-RN SUPERVISION OF NURSING CARE
		A0144-PATIENT RIGHTS: CARE IN SAFE SETTING
		A0043-GOVERNING BODY
		A0115-PATIENT RIGHTS
		A0174-PATIENT RIGHTS: RESTRAINT OR SECLUSION
		A0385-NURSING SERVICES
		Federal - Not Related to any Intakes
		A0000-INITIAL COMMENTS
3K0D12	10/30/2014	
		Federal - Link to This Intake
		A0144-PATIENT RIGHTS: CARE IN SAFE SETTING
		A0043-GOVERNING BODY
		A0174-PATIENT RIGHTS: RESTRAINT OR SECLUSION
		A0385-NURSING SERVICES
		A0115-PATIENT RIGHTS
		A0395-RN SUPERVISION OF NURSING CARE
		Federal - Not Related to any Intakes
		A0000-INITIAL COMMENTS

EMTALA INFORMATION - No Data

DEEMED/RO APPROVAL INFORMATION

Ro Request for Approval: 09/22/2014 **RO Approval Date:** 09/22/2014

Printed: 10/30/2014 1:29:33PM
Due Date: 09/24/2014
Priority: IJ

Intake ID: NC00100627
Facility ID: 933410 / HOSP-ACU
Provider Number: 340040
State Region: NCE

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ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	09/30/2014	09/30/2014	10/01/2014	[redacted]

INVESTIGATIVE NOTES - No Data

CONTACTS - No Data

AGENCY REFERRAL - No Data

LINKED COMPLAINTS - No Data

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

Reason for Restraint:
Cause of Death:

NOTICES

Letters:

Created	Description
09/25/2014	ACUTE HOSP - ACKNOWLEDGE/Complainant
10/06/2014	ACUTE HOSP - COMPLAINANT NO SUMMARY/Complainant

Notification:

Date	Type	Party	Method
09/25/2014	Acknowledgement to Complainant	Central Office	Written
10/06/2014	Acknowledgement to Complainant	Central Office	Written

PROPOSED ACTIONS

Proposed Action	Proposed Date	Imposed Date	Type
Involuntary Termination - IJ	10/01/2014		Federal

END OF COMPLAINT INVESTIGATION INFORMATION